OPPOSITIONAL DEFIANT & CONDUCT DISORDERS

Introduction

Although it is normal for both children and adolescents to exhibit some type of oppositional behavior as they mature, some children and adolescents exhibit behaviors that are significantly disruptive to the point where they may impair functioning. Such troublesome and provoking behaviors comprise a host of syndromes and typically are behaviors exhibited by children who are diagnosed with oppositional defiant disorder (ODD) and conduct disorder (CD).

Typically, children who suffer from these mental health disorders display behavior that is disturbing and potentially dangerous, as well as disruptive (Boesky, 2002). ODD and CD are often referred to as the "disruptive disorders" (Boesky).

Disruptive disorders are complex and may lead to long-term adverse consequences affecting academic performance, as well as difficulties in social and emotional development. Children with CD and ODD are also at high risk for criminality and antisocial personality disorders in adulthood (Rutter, 1997).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV),* as cited by Loeber (2000), the essential features of ODD are recurrent patterns of negativistic, defiant, disobedient, and hostile behavior toward authority figures, which leads to impairment. The primary features of CD are a repetitive and persistent pattern of behavior in which the basic rights of others and major age-appropriate societal norms or rules are violated (Loeber, 2000).

There has been much debate on the degree that ODD and CD relate to each other and how they are distinguished from one another. The majority of empirical evidence supports a distinction between the two disorders and ADHD (Cohen et al., as cited by Loeber, 2000). Table 1 outlines the prevalence rates of both ODD and CD.

Table 1

Key Facts for Disruptive Behaviors

Oppositional Defiant Disorder (ODD)

- ODD is reported to affect between 2 and 16% of children (Medical Center of Central Georgia, 2002).
- ODD is more common in boys than in girls before puberty (U.S. Department of Health and Human Services, 1999).
- After puberty, the rates in both genders are equal. (U.S. Department of Health and Human Services).

Conduct Disorder (CD)

- Approximately 6% of children have CD.
- CD is more common in boys than in girls by a 4:1 ratio.
- CD is believed to be more prevalent in urban than in rural settings.
- Children with CD often have other psychiatric problems.
- The prevalence of CD has increased over recent decades.
- Aggressive behavior is the reason for one-third to one-half of the referrals made to child and adolescent mental health services.

Source: Medical Center of Central Georgia, 2002.

Oppositional Defiant Disorder (ODD)

ODD is a relatively new diagnosis that describes children with behavior problems that do not meet the criteria for full-blown CD (Murphy et al., 2001). ODD is typically considered a mental disorder where the child exhibits noncompliance towards authority figures (Boesky, 2002). According to Chandler (2002), ODD is a psychiatric disorder that is characterized by two different sets of problems: aggressiveness and a tendency to purposefully bother and irritate others. It is an enduring pattern of uncooperative, defiant, and hostile behavior to authority figures without major antisocial violations (Christophersen & Mortweet, 2001).

ODD often occurs before conduct disorder and may be an early sign of conduct disorder (U.S. Department of Health and Human Services, 1999). ODD is diagnosed when a child's behavior is hostile and defiant for six months or longer and is thought to start in the preschool years, whereas conduct disorder generally appears when children are somewhat older (Lavigne et al., 2001). ODD is not diagnosed if conduct disorder is present (U.S. Department of Health and Human Services, 1998). The diagnostic criteria for ODD are listed in Table 2.

Conduct Disorder (CD)

Children with CD exhibit persistent and critical patterns of misbehavior. These children may indulge in frequent temper-tantrums like children with ODD; however, they also violate the rights of others (Center for the Advancement of Children's Mental Health at Columbia University, 2000). Behaviors exhibited by children with CD include aggression towards people or animals, destruction of property, deceitfulness, theft, or serious violation of rules (Murphy et al., 2001).

Table 2

DSM-IV Criteria for Oppositional Defiant Disorder

A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:
   1. often loses temper;
   2. often argues with adults;
   3. often actively defies or refuses to comply with adults' requests or rules;
   4. often deliberately annoys people;
   5. often blames others for his or her mistakes or misbehavior;
   6. is often touchy or easily annoyed by others;
   7. is often angry and resentful; or
   8. is often spiteful or vindictive.

   Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.

D. Criteria are not met for Conduct Disorder. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Source: Christophersen & Mortweet, 2001.

According to research compiled by Christophersen & Mortweet (2001), the diagnosis of CD is usually based on the persistence and the repetition of the behavior. Furthermore, CD may first occur in childhood or in adolescence and may have mild, moderate, or severe classifications. The lack of specific subtyping may result in CD being over-inclusive and associated with other mental disorders.

Children diagnosed with CD have more difficulty in areas of academic achievement, interpersonal relationships, drugs, and alcohol use (Boesky, 2002). They also are often exposed to the juvenile justice system because of their delinquent or disorderly behaviors. For example, Ferguson and Horwood, as cited in Boesky, found that 90% of children with three or more CD symptoms at age 15 were self-reported frequent offenders a year later, compared to 17% of children with no CD symptoms. In addition, according to Murphy (2001), 25 to 40% of children with CD have adult antisocial personality disorder later in life. Table 3 lists the criteria for CD as classified in the *DSM-IV*.

There are two specific subtypes of CD: childhood onset and adolescent onset (Braithwaite et al., 2001). In the first, onset occurs before the age of 10, with the child displaying one criterion (Braithwaite et al.). Children diagnosed with childhood onset CD are typically male, often display physical aggression, have disturbed peer relationships, and may have had ODD during early childhood (Braithwaite et al.). These children typically develop full criteria for CD before they reach puberty (Braithwaite et al.). In the second subtype, onset usually occurs during adolescence, and is defined by the absence of CD at the age of 10 (Braithwaite et al.). These children are less likely to display aggressive behaviors than children in the first subtype. They will also have more normal peer relationships and are less likely to develop adult antisocial personality disorder (Braithwaite et al.). Late-onset is the only type of CD for females (Loeber, 2000).

Table 3

DSM-IV Criteria for Conduct Disorder

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

Aggression towards people and animals:

1. often bullies, threatens, or intimidates others;
2. often initiates physical fights;
3. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun);
4. has been physically cruel to people;
5. has been physically cruel to animals;
6. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery);
7. has forced someone into sexual activity.

Destruction of property:

8. has deliberately engaged in fire setting with the intention of causing serious damage;
9. has deliberately destroyed others' property (other than by fire setting).

Deceitfulness or theft:

10. has broken into someone else's house, building, or car;
11. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others);
12. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering, forgery);

Serious violations of rules:

13. often stays out at night despite parental prohibitions, beginning before age 13 years;
14. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period);
15. is often truant from school, beginning before age 13.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Source: Christophersen & Mortweet, 2001.

Relationship between ODD and CD

ODD and CD are characterized by antisocial behavior and, accordingly, are considered a group of behaviors rather than actual impairments (U.S. Department of Health and Human Services, 1999). The linkage between ODD and CD has been examined in several studies (Biederman et al., Frick et al., Lahey et al., Loeber et al., as cited in Lavigne et al., 2001). These studies indicate that ODD is usually present as a forerunner to childhood-onset CD, but most children with ODD do not develop CD. In a recent study, 56% of males and 62% of males with CD also met criteria for ODD (*The Brown University Child and Adolescent Psychopharmacology Update*, 2004).

While some features of ODD and CD overlap, there are important distinctions (Searight et al., 2001). Children with ODD do not typically display significant physical aggression and may be less likely to have problems with the law (Searight et al.).

According to Boesky (2002), a subset of children diagnosed with ODD may ultimately develop CD. Moreover, because ODD is seen as a disorder of noncompliance and CD involves the violation of another's rights, it is helpful to view these mental health disorders as two points on a continuum, rather than as two separate mental health disorders. Most children with CD begin with ODD-like behaviors (Kazdin, as cited in Boesky). As stated previously, although children with ODD may develop CD, many do not. Although the precise relationship between ODD and CD is not explicit, it is known that early intervention and treatment of ODD may avert the development of CD.

Causes and Risk Factors

According to the Center for the Advancement of Children's Mental Health at Columbia University (2000), research is needed to pinpoint the exact causes of both ODD and CD. It is surmised that a genetic vulnerability, combined with environmental factors, may influence the disorder, as well as its disruptive behaviors. Some of these environmental factors include: family histories of disruptive behavior disorder; antisocial personality disorder; mood disorders or substance abuse; permissive, neglectful, harsh or inconsistent parenting; and poverty. CD may also be associated with a variety of awkward living conditions such as overcrowding, poor housing, and disadvantaged school setting (Hibbs & Jensen, 1996, p. 380). Thus, it is important to account for all of these conditions because the development, maintenance, and course of treating CD may also be impacted by them. Second, there is no one cause or influencing factor. Frequently, the problem behaviors exhibited by children with ODD and CD may be indicative of underlying psychiatric, neurological or learning problems (National Alliance for Mental Health Wisconsin, 2002). Conversely, co-existing conditions have been found to exacerbate behavioral problems.

The symptoms for CD and ODD can vary (Boesky, 2002). Not every child reacts the same way to these various influencing factors. Moreover, viewing both CD and ODD as mental disorders, without considering the factors causing the disorder, is misleading.

Given the high co-morbidity rate of CD with ADHD, Tourette's syndrome, and other disorders known to be due to neurological dysregulations, there is the possibility that CD may also be a result of neurological dysregulations (Braithwaite et al., 2001). However, no studies have investigated neurological disorder to be the basis for CD (Braithwaite et al.).

Comorbidity

ODD and CD are frequently found in children who suffer from ADHD, another disruptive disorder, which is discussed separately in this report (Center for Advancement of Children's Mental Health, 2000). For all children diagnosed with CD, co-occurrence with ADHD is at least 50% (Tynan, 2006). Children who develop CD often show signs of this disorder at an earlier age. The onset of CD typically occurs earlier in boys diagnosed with ADHD (Loeber, 2000). Studies have determined that, in 92% of boys referred with ADHD who developed CD, the onset of CD occurred prior to age 12 (Biederman et al., Hinshaw et al., as cited in Loeber). The co-occurrence of CD and ADHD makes it more difficult to discriminate between the disorders (Tynan).

A recent study of co-morbidity levels for children diagnosed with ODD or CD determined that 36% of females and 46% of males with ODD met criteria for at least one other disorder (*The Brown University Child and Adolescent Psychopharmacology Update*, 2004). Thirty-nine percent of females and 46% of males diagnosed with CD also met criteria for another disorder (*The Brown University Child and Adolescent Psychopharmacology Update*). Cross-sectional studies of

individuals with mood disorders and/or anxiety disorders, along with CD, indicate comorbidity of 32 to 37% (Tynan, 2006).

According to analysis compiled by Lavigne et al., ODD may precede the development of anxiety and mood disorders (2001). Some children may develop co-morbidity of ODD with another disorder in the elementary school age range. Such co-morbidity may develop with ADHD, and some young children with ODD may later develop anxiety or depressive disorders comorbid with ODD. This study found that, in the preschool years, a shift from ODD to either anxiety or depression, without any co-morbidity in the early grades, is uncommon. Several studies have also documented a strong association between CD and substance use (Whitmore et al., Windle, as cited in Loeber, 2000) with CD as the psychiatric disorder most strongly associated with substance abuse.

Loeber (2000) conducted a literature review of the co-morbidity of CD and found that comorbid conditions in girls with CD are relatively predictable. He asserted that, in general, adolescent girls are more at risk for anxiety and depression. Accordingly, there is an increased risk for such disorders in girls with CD. Thus, gender and age are crucial indicators in determining and diagnosing comorbid conditions with CD. Several other features of CD are relevant because children with CD are also more likely to show deficiencies in academics, as well as with a variety of cognitive processes. There is a strong relationship between CD and academic failure and possible learning disabilities (Tynan, 2006). Thus, complexity of this disorder appears to be the norm.

Diagnosis

There are no definitive psychological or biological tests for diagnosis of disruptive disorders (University of British Columbia, 2004). The accurate diagnosis of disruptive disorders requires an assessment involving two different assessment methods (Christophersen & Mortweet, 2001). In addition, such an assessment may help detect patterns of co-occurring disorders. Assessments may include interviews on family history and child-rearing practices, as well as behavior rating scales.

The following diagnosis criteria are outlined by the Center for the Advancement of Children's Mental Health at Columbia University (2003). The mental health provider, after interviewing the child, family, and teachers, should also evaluate the course of the child's development, especially through school records. Particular attention should be paid to any oppositional or aggressive behavior that is not age-appropriate. For a diagnosis of ODD, a pattern of negative, hostile defiant behavior which reflects significant impairment in social and academic functioning and which has persisted for at least six months must be established. It must also be confirmed that the behavior has not occurred in the course of a psychotic or mood disorder.

To make a diagnosis of CD, the mental health clinician must ascertain whether the child has shown at least three major symptoms in the last three months, with one of the symptoms having occurred in the last six months. These symptoms must have occurred in various settings. The behavior must cause significant impairment in the child's social or academic life. Because CD usually occurs with another disorder, mental health clinicians should also look for other co-occurring disorders, such as ADHD. CD has no age limit and, in a child younger than age 10, the repetitive presence of only one of the 15 behaviors in the *DSM-IV* is sufficient for diagnosis (Tynan, 2006).

Prevention

Recent studies pertaining to ODD and CD are focusing on efforts to prevent disruptive disorders from developing (University of British Columbia [UBC], 2004). Goals of prevention programs are to intervene early and mitigate risk factors, thus reducing the number of new cases (UBC, 2004). Prevention programs may be either universal, focusing on entire populations, or targeted, which are directed towards children who have been labeled high-risk (UBC, 2004). More research is needed to determine the effect of prevention programs on disruptive disorders.

Treatments

According to analysis compiled by Burns et al. (1999), disruptive disorders are considered very difficult to treat. Various treatment modalities are utilized for treating these disorders as well as the comorbid disorders, which accompany ODD and CD.

The Center for the Advancement of Children's Mental Health (2000) maintains that, for some children with CD, behavior therapy can be used to teach new ways to resolve conflict through role playing and rehearsal. Furthermore, family functioning and the child's prognosis may be improved by parental management training. Parental management training helps parents to better understand the disorder and to learn strategies for dealing with their child. Further research has found, that among these two behavioral disorders, ODD has shown the best response to psychotherapy. Academic and social rehabilitation are also beneficial, as are certain forms of group therapy that use behavioral therapy techniques.

Murphy et al. (2001) state that treatment for ODD and CD usually involves individual and family therapy. Frequently, some children may need to be removed from the home and placed in foster care. It is also necessary to consider the other comorbid disorders that accompany CD that require treatment, such as ADHD, developmental disabilities, substance abuse disorder, anxiety disorders and mood disorders. CD requires early intervention, extensive treatment in multiple domains, and long-term follow-up (Offord & Bennett, as cited in Children's Mental Health Ontario, 2001). Parents who retain custody of a child with CD are taught limit-setting, consistency, and other behavioral techniques. Medication is only used to treat comorbid ADHD and moods disorder, but not CD itself. Furthermore, early diagnosis and intervention is the key to improved prognosis in the outcome of CD. However, there is no single effective treatment for this disorder. If CD is diagnosed along with another disorder, the other disorder is treated first (Center for the Advancement of Children's Mental Health at Columbia University, 2000).

Evidence-based Treatments

According to the U.S. Department of Health and Human Services (1999) and Burns et al. (1999), there are several psychosocial interventions that can effectively reduce antisocial behavior in disruptive disorders. After more than 80 studies were performed, two treatments met criteria for well-established treatments and 10 for probably efficacious treatment. These psychosocial interventions, which are proven effective, have had positive results in the treatment of boys (Technical Assistance Partnership, 2002).

Parent Management Training Techniques

The following treatments are discussed by the U.S. Department of Health and Human Services (1999) and Burns et al. (1999) as being well-established. There are two treatments that are directed at training parents and which have been proven successful in reducing problem behaviors; these are particularly effective with children diagnosed with ODD. Parent management training had the most

significant amount of support, with 26 studies supporting this treatment approach (Chorpita & Daleiden, 2007). One of these treatments is a parent-training program based on the manual *Living with Children* (Bernal et al., as cited in Burns and the U.S. Department of Health and Human Services). The other is a videotape modeling parent training (Spaccarelli et al., as cited in Burns and the U.S. Department of Health and Human Services).

Living With Children – This treatment approach, which is based on Gerald Patterson's coercion theory, attempts to change the patterns of interactions between parents and their children and to reduce the child or adolescent's problem behavior (Society of Clinical Child and Adolescent Psychology, 2006). This treatment appears to be most successful for male and females ages 6 to 16 (Society of Clinical Child and Adolescent Psychology). According to the U.S. Department of Health and Human Services, this treatment teaches parents to reward desirable behaviors and ignore or punish deviant behaviors, based on principles of operant conditioning. Parents are instructed to read parts of these training manuals and therapists use the manuals as a guide for conducting the interventions. The parent training consisted of 8 to 10 clinic sessions in which a parent is taught to pay attention to and reward appropriate behavior and to ignore inappropriate behavior. The parents are then instructed on issuing commands and using reinforcement for compliance and time-out for noncompliance. Teaching procedures involved didactic instruction, modeling, role play, interaction with the child in the clinic, and structured times to practice skills in the home.

This type of parent training and social learning intervention has been found to be an effective method for decreasing deviant behavior. Furthermore, additional review has shown that such parent training has been carefully documented and empirically supported.

Videotape modeling parent training – As stated by the U.S. Department of Health and Human Services, this form of treatment provides a series of videotapes covering parent-training lessons, after which a therapist leads a group discussion of the videotape lessons. The information below is taken from the Society of Clinical Child and Adolescent Psychology (2006). This treatment is generally administered in a group setting, led by a therapist, with opportunity to discuss the videotaped lessons after viewing. This treatment is best used with parents of children ages 4 to 8.

Table 4

Ways Parents Can Help a Child with ODD

- Build on the positive; give your child praise and positive reinforcement.
- Be a good model for your child. Take a break if you are about to make a conflict worse, not better.
- Choose your battles wisely. Prioritize things you want your child to do.
- Establish reasonable, age appropriate limits with consequences that can be easily enforced.
- Work with and obtain support from other adults, e.g., teachers, coaches, and spouse.
- Manage your own stress.

Source: American Academy of Child & Adolescent Psychiatry (AACAP), 1999.

The following treatments discussed are efficacious in that they have been successful in treating children, particularly in clinical trials. These treatments are discussed by Burns and outlined in the Technical Assistance Partnership for Child and Family Mental Health, 2002.

Cognitive Behavioral Approaches

According to the Technical Assistance Partnership for Child and Family Mental Health (2002), there are several behavioral approaches for treating CD and ODD. These approaches include: Multisystemic Therapy by Scott Henggeler; Anger Coping Therapy by Lochman and Lochman; Assertiveness Training by Huey and Rank; Delinquency Prevention Program by Tremblay and Vitaro; Rational Emotive Therapy by Block; Videotape Modeling Parent Training by Webster-Stratton; and Parent-Child Interaction Therapy by Eyberg and McNeil.

Multisystemic Therapy

According to the University of Virginia Institute for Law, Psychiatry, and Public Policy, an intervention model with proven success in treating adolescents with CD is Multisystemic Therapy (MST). MST is particularly effective for treating youth with CD because it applies techniques that promote detachment from deviant peers, builds stronger bonds to the family and school, enhances family management skills such as monitoring and discipline, and builds develop greater social and academic competence (Brunk, 2000). Treatment addresses the needs of the youth and family. Results of studies with hostile and antisocial youth have show that MST is effective in reducing conduct problems and improving family functioning. (For more information on MST, please refer to the "Juvenile Offenders" section in the *Collection*.)

Pharmacological Treatment

As found by Boesky (2002), there is no one type of medication usually prescribed for ODD and CD because there has been no one class of medication found to be beneficial. Psychostimulants may be prescribed for concurrent problems with impulsivity and hyperactivity. Antidepressants may also be prescribed to youth with mood disorders. Medication may also help with co-occurring mental health disorders, making it more likely the child will be able to participate and benefit from intervention strategies. In the short term, stimulant medicine has proven effective in controlling symptoms of inattention, impulsivity, and hyperactivity (Tynan, 2006). However, stimulant medication does not result in improved parent-child, teacher-child, or peer relationships (Tynan). Similar to approaches used to treat ADHD, a multidisciplinary and multimodal approach to treatment is required (Tynan). No medication is consistently effective in the treatment of CD when ADHD is not present. Because substance abuse frequently co-occurs with CD, clinicians should use caution when prescribing stimulants.

According to the U.S. Department of Health and Human Services, while no drugs have been found to be consistently effective in treating CD, four drugs have been tested (1999). Lithium and methylphenidate have been found to reduce aggressiveness in children with CD (Campbell et al., Klein et al., as cited by the U.S. Department of Health and Human Services). Some studies; however, could not establish that lithium was effective. Additional research studies found that methylphenidate was superior to lithium and that carbamazepine was frequently effective, but multiple side effects were also reported (Kafantaris et al., as cited by the U.S. Department of Health and Human Services). In studies of Clonidine, patients showed a significant decrease in aggressive behavior, but exhibited significant side effects that would require monitoring of cardiovascular and blood pressure parameters (Kemph et al., as cited by the U.S. Department of Health and Human Services).

As stated by Christophersen & Mortweet (2001), there is limited support for pharmaceutical treatments for ODD. Studies have shown that such a treatment approach is not effective for children with ODD. However, children with ADHD and ODD may benefit from stimulants or tricyclic antidepressants. Pharmacotherapy should not be utilized as the sole treatment for a child with ODD or CD unless prescribed for comorbid disorders. In addition, medications must be prescribed only in conjunction with psychological interventions such as parent training.

Unproven Treatments

Research indicates that therapy for disruptive disorders should involve treatments that are delivered with enough frequency and duration to produce the desired treatment outcomes (Children's Mental Health Ontario, 2001). There is little research supportive of single-session or brief interventions or for approaches such as boot camps, psychiatric hospitalization, medication trials, or a brief course of cognitive-behavioral therapy (Cowles et al. as cited in Children's Mental Health Ontario). Boot camps have consistently demonstrated good initial results but long-term declines: boot camp graduates experience higher rates of arrests and commit more serious crimes (Tynan, 2006). Poor long-term outcomes following this treatment may be due to group reinforcement of criminal activity accompanied by lack of family or community change (Tynan). Moreover, group treatment may also have possible negative adverse effects.

Individual psychotherapy as a single treatment has not proven effective for CD, although individual sessions may facilitate treatment compliance (Tynan, 2006). Individual counseling may help a child who is trying to follow a more structured and comprehensive treatment program.

Other Treatment Issues

ODD and CD are more prevalent among adolescents from families with low socioeconomic status (Loeber, 2000). CD is more common in neighborhoods characterized by social disorganization and high crime rates (Loeber). More research is needed to assess the differences of CD and ODD in rural and urban environments, given that results from current research are mixed and the poor prognosis of CD is associated with urban areas (Loeber).

The following information is attributed to Tynan (2006). Recent research suggests that the severity of the CDD and ODD, rather than the age of the child, may be a predictor of treatment failure. However, improvements have been documented in all age ranges and all levels of severity. Common elements in successful treatments are high structure, specific goals, and clear behavioral techniques. These treatment components improve communication and problem solving skills, as well as reinforce prosocial behaviors.

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Organizations/Weblinks

Child, Adolescent and Family Branch Center for Mental Health Services
5600 Fishers Lane, Room 18-49 - Bethesda, MD 20857
800-789-2647

Focus Adolescent Services
Teen Behavior Problems and Behavioral Disorders
http://www.focusas.com/BehavioralDisorders.html

Internet Mental Health
Oppositional Defiant Disorder
http://www.mentalhealth.com/dis/p20-ch05.htm

notMYkid.org
Oppositional Defiant Disorder
http://www.notmykid.org/parentArticles/ODD/default.asp

University of Virginia Health System
P.O. Box 800224 - Charlottesville, VA 22908
434-924-3627
http://www.healthsystem.virginia.edu/uvahealth/adult_mentalhealth/odd.cfm

Virginia Commonwealth University Health System
1250 East Marshall Street - Richmond, VA 23298
804-828-9000
http://www.vcuhealth.org